



FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

DEPARTMENT OF FINANCE
141 PRYOR STREET SW STE 7001, ATLANTA, GA 30303

(404) 612-7606 (Pension Office)

(404) 612-1312 (E-Fax)

RETIREMENT INFORMATION

PRIOR TO YOUR LAST DAY ON DUTY, THE PENSION OFFICE NEEDS:

- COPY OF YOUR BIRTH CERTIFICATE
- COPY OF SPOUSE'S BIRTH CERTIFICATE AND SOCIAL SECURITY CARD
- COPY OF CHILDREN BIRTH CERTIFICATE
(MINOR CHILDREN UNDER THE AGE OF 18 AND/OR COLLEGE STUDENTS UP TO AGE 26)
- COPY OF MARRIAGE CERTIFICATE
- COPY OF YOUR MEDICARE CARD, IF APPLICABLE (DISABLED OR AGE 65 OR OVER)
- COPY OF SPOUSE'S MEDICARE CARD, IF APPLICABLE (DISABLED OR AGE 65 OR OVER)
- COPY OF TERMINATION/RETIREMENT LETTER SUBMITTED TO YOUR MANAGER OR DEPARTMENT HEAD

PRIOR COMPLETE THE FOLLOWING ENCLOSED FORMS:

- PENSION APPLICATION
- BENEFICIARY FORM
- DEDUCTION TO MAINTAIN IN RETIREMENT
(INCLUDE DEPOSIT SLIP FOR CREDIT UNION DEDUCTIONS)
- DIRECT DEPOSIT FORM (INCLUDE A VOIDED CHECK)
- W-4 TAX WITHHOLDING FORM
- HEALTH INSURANCE ENROLLMENT FORM
- LIFE INSURANCE ENROLLMENT CARD
- COPY OF SIGNED/SAVED AFFIDAVIT

PLEASE NOTE: Payout of your accrued vacation, holiday and/or comp time will not be directly deposited. You will receive a paper check. Please advise your payroll rep if you want your check mailed or if you will pick up your check. After you have been paid out your accrued leave balances and are off payroll, your Pension will be presented to the Pension Board for approval. The Pension Board meets the 2nd Wednesday of every month and Pension checks are paid on the 1st of each month. If the 1st falls on a weekend, checks will be paid on the previous business day.

Retiree Health Benefits Information:

As you transition from active employee to retiree, you may receive a letter from Blue Cross Blue Shield of Georgia advising you that your health benefits has expired as an active employee and that you may apply of Cobra. Since you are retiring from the county, please disregard that letter. Your retiree health benefits will be effective the month after your health benefits expire as an active employee. Also, please bear in mind that during this transition, there will be a delay in your health benefits coverage. *Therefore, after you have received your final pay for your accrued leave balance of vacation, holiday and/or comp time from the county. Please try to schedule your doctor's appointments after the 10th of the following month of your final pay check from the county.* ER appointments will be handled on a case by case basis. If you have any questions regarding this process, please call **Retiree Benefits at (404) 612-7606.**



**IMPORTANT INFORMATION FOR CASH WITHDRAWAL/ROLLOVERS
FROM TIAA-CREF 457B DEFERRED COMPENSATION ACCOUNTS**

- TIAA-CREF requires that Fulton County provide the date of separation for participants before they can release their 457B Account Funds. Fulton County will NOT provide separation dates until employees receive their last check as an ACTIVE employee (Pay Out of Leave Check/Final Check) from Fulton County, and are placed off payroll. The Personnel Department staff updates the Payroll System with employees' employment status as being separated and Off Payroll approximately one (1) month after the last date of employment.
- Employees that are planning to retire or EXIT Fulton County and request to have their Pay Out of Leave Check (last check as an ACTIVE Employee) deferred into their 457 Account need to meet with finance Department Payroll Staff only to verify the Pay Out of Leave Check documents are complete for processing last check as an ACTIVE employee with Fulton County.
- Employees requesting to make Federal and State Tax Adjustments with their Pay Out of Leave Check/Final Check need to meet with Payroll Staff only to verify (ALL) tax documents are complete for processing last check as an active employee with Fulton County. Please contact 404-612-7605, if you have any questions.
- Loan and Unforeseeable Emergency Withdrawals – employees must contact TIAA-CREF directly. TIAA-CREF determines if an employee is eligible NOT Fulton County. TIAA-CREF is Fulton County's Plan Administrator. The call center telephone number is 800-842-2252.



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APPLICATION FOR RETIREMENT

☐ STANDARD ☐ AGE PENALTY ☐ BENEFICIARY ☐ DISABILITY ☐ LINE OF DIASBILITY

The undersigned does hereby apply for retirement benefits under the _____ Law,
effective _____.

Name _____ SS# _____

Address _____

Telephone No. _____

Department _____ Last Day on Duty _____

Date of Birth _____ Date of Marriage _____

Employees Association (maintain membership) Yes _____ No _____

Name of Spouse _____

Spouse Date of Birth _____ SS# _____

Sworn to and subscribe before me this _____ day of _____.

Notary Public

Applicant Signature

CERTIFICATE OF AUDITOR

For pension is _____ years of age, has regularly contributed to the Pension Fund of said County
pursuant to law, and that they have been in the employ of Fulton County as represented in their petition

_____ years which may include prior service credit, according to Fulton County records, and
that if it is satisfactorily shown to the Pension Board that the facts stated in the petition are true, then the
Pension Board of Fulton County is authorized to grant to the petitioner a monthly pension in the amount
of \$ _____ per month, effective _____, 20 _____.

APPROVED BY:

ATTORNEY

AUDITOR

Date: _____

Date: _____



FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

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BENEFICIARY FORM

NAME

SOCIAL SECURITY NO.

DEPARTMENT

DATE OF BIRTH

EMPLOYMENT DATE

BENEFICIARY STATEMENT FOR

SINGLE STATUS EMPLOYEES AND EMPLOYEES WITH LESS THAN TEN YEARS OF CREDITABLE SERVICE

In the event of my death before retirement and before becoming eligible for my beneficiaries to receive pension benefits, I direct that a lump sum payment of my contribution (or any undistributed balance thereof) be made to:

Please include name(s), address and social security numbers of Beneficiary

If there are no spouse or minor children, you can say "Executor of my Estate" ... include the person(s) name and address

EMPLOYEES WITH TEN OR MORE YEARS OF CREDITABLE SERVICES

Your spouse and/or minor children under the age of 18 are automatically beneficiaries under the pension plan. It is the duty of each employee to notify the Pension division of any change in the status of beneficiaries, such as birth of children death of spouse or divorce.

Name of Spouse _____

SS# _____

Spouse's Date of Birth _____

Date of Marriage _____

Minor Children Under the age of 18 Years:

Name	Date of Birth	Social Security#

Signature _____

Date _____

Witness _____

Date _____



DEDUCTIONS TO MAINTAIN IN RETIREMENT

(COMPLETE AND RETURN WITH APPLICATION)

CREDIT UNION DEDUCTIONS

(INCLUDE DEPOSIT SLIP FOR PROCESSING)

A) ASSOCIATED FEDERAL CREDIT UNION (CRED1)

YES _____

NO _____

AMOUNT \$ _____

B) EXCEL FEDERAL CREDIT UNION (CRED2)

YES _____

NO _____

AMOUNT \$ _____

C) CITY OF ATLANTA (CRED3)

YES _____

NO _____

AMOUNT \$ _____

US SAVINGS BOND

(DEDUCTION MUST BE CURRENTLY SETUP AS AN ACTIVE EMPLOYEE)

YES _____

NO _____

AMOUNT \$ _____

SIGNATURE

DATE



FULTON COUNTY EMPLOYEES RETIREMENT SYSTEM

DEPARTMENT OF FINANCE
141 PRYOR STREET SW STE 7001, ATLANTA, GA 30303

(ACH CREDITS) PENSION PAYROLL DEPOSIT AUTHORIZATION FORM

COMPLETE AND RETURN TO THE PENSION DIVISION

Please include a VOIDED CHECK for processing

Write "VOID" on the Check

BANK _____

CITY _____

RETIREE NAME _____

BANK ABA NO. _____

ACCOUNT NUMBER _____

I hereby authorize Fulton County Pension Board and the Bank listed to deposit my net pension pay automatically to my account each pay day. This authorization will remain in effect until I have provided written notification to cancel.

SIGNATURE

DATE



RETIREE

Fulton County, Georgia Group Life Insurance Enrollment/Change Form

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH
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Coverage Selection:

_____ Basic Life Coverage \$10,000 No Retiree Cost

(Check Only One Dependent Life Option)

_____ Dependent Life \$10,000 per dependent \$.85 per month

_____ Dependent Life Waived or Not Applicable No Retiree Cost

Eligible Dependent: (Spouse or Child up to age 26)

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY DESIGNATION: If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary (ies). If you list benefit percentages, the total must equal 100%. (Retiree is the beneficiary of proceeds from dependent coverage.)

FIRST NAME	LAST NAME	SOCIAL SECURITY #	RELATIONSHIP & ADDRESS	BENEFITS %
Primary				
Primary				
Contingent				
Contingent				

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED. I UNDERSTAND THAT ANY INDIVIDUAL DEPENDENT CAN ONLY BE COVERED ONCE IN THIS GROUP LIFE INSURANCE PLAN.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime and subjects such person to criminal and civil penalties. INFORMATION ON THIS FORM WILL OVERRIDE ANY PRIOR SELECTION OR DESIGNATION FOR THE POLICY (IES) LISTED ABOVE.

RETIREE SIGNATURE _____

DATE ____/____/____

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

2020

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to www.irs.gov/FormW4P.

Purpose of form. Form W-4P is for U.S. citizens, resident aliens, or their estates who are recipients of pensions, annuities (including commercial annuities), and certain other deferred compensation. Use Form W-4P to tell payers the correct amount of federal income tax to withhold from your payment(s). You may also use Form W-4P to choose (a) not to have any federal income tax withheld from the payment (except for eligible rollover distributions or for payments to U.S. citizens to be delivered outside the United States or its possessions), or (b) to have an additional amount of tax withheld.

Your options depend on whether the payment is periodic, nonperiodic, or an eligible rollover distribution, as explained on pages 2 and 3. Your previously filed Form W-4P will remain in effect if you don't file a Form W-4P for 2020.

General Instructions

Section references are to the Internal Revenue Code.

Follow these instructions to determine the number of withholding allowances you should claim for pension or annuity payment withholding for 2020 and any additional amount of tax to have withheld. Complete the worksheet(s) using the taxable amount of the payments.

If you don't want any federal income tax withheld (see *Purpose of form*, earlier), you can skip the worksheets and go directly to the Form W-4P below.

Sign this form. Form W-4P is not valid unless you sign it.

You can also use the estimator at www.irs.gov/W4App to determine your tax withholding more accurately. Consider using this estimator if you have a more complicated tax situation, such as if you have more than one pension or annuity, a working spouse, or a large amount of income outside of your pensions. After your Form W-4P takes effect, you can also use this estimator to see how the amount of tax you're having withheld compares to your projected total tax for 2020. If you use the estimator, you don't need to complete any of the worksheets for Form W-4P.

Note that if you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty

unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return.

Filers with multiple pensions or more than one income. If you have more than one source of income subject to withholding (such as more than one pension or a pension and a job, or you're married filing jointly and your spouse is working), read all of the instructions, including the instructions for the Multiple Pensions/More-Than-One-Income Worksheet, before beginning.

Other income. If you have a large amount of income from other sources not subject to withholding (such as interest, dividends, or capital gains), consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. See Pub. 505, Tax Withholding and Estimated Tax, for more information. Get Form 1040-ES and Pub. 505 at www.irs.gov/FormsPubs. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 5 or the estimator at www.irs.gov/W4App to make sure you have enough tax withheld from your payments. If you have income from wages, see Pub. 505 or use the estimator at www.irs.gov/W4App to find out if you should adjust your withholding on Form W-4 or Form W-4P.

Note: Social security and railroad retirement payments may be includible in income. See Form W-4V, Voluntary Withholding Request, for information on voluntary withholding from these payments.

Withholding From Pensions and Annuities

Generally, federal income tax withholding applies to the taxable part of payments made from pension, profit-sharing, stock bonus, annuity, and certain deferred compensation plans; from individual retirement arrangements (IRAs); and from commercial annuities. The method and rate of withholding depend on (a) the kind of payment you receive; (b) whether the payments are to be delivered outside the United States or its possessions; and (c) whether the recipient is a nonresident alien individual, a nonresident alien beneficiary, or a foreign estate. Qualified distributions from a designated Roth account or Roth IRA are nontaxable and, therefore, not subject to withholding. See page 3 for special withholding rules that apply to payments to be delivered outside the United States and payments to foreign persons.

----- Separate here and give Form W-4P to the payer of your pension or annuity. Keep the worksheet(s) for your records. -----

Withholding Certificate for Pension or Annuity Payments

OMB No. 1545-0074

2020

► For Privacy Act and Paperwork Reduction Act Notice, see page 6.

Your first name and middle initial	Last name	Your social security number
Home address (number and street or rural route)		Claim or identification number (if any) of your pension or annuity contract
City or town, state, and ZIP code		

Complete the following applicable lines.

- Check here if you **do not want any** federal income tax withheld from your pension or annuity. (Don't complete line 2 or 3.) ► ☐
- Total number of allowances and marital status you're claiming for withholding from each **periodic** pension or annuity payment. (You may also designate an additional dollar amount on line 3.) ►
Marital status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. (Enter number of allowances.)
- Additional amount, if any, you want withheld from each pension or annuity payment. (**Note:** For periodic payments, you can't enter an amount here without entering the number (including zero) of allowances on line 2.) ► \$

Your signature ►

Date ►



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STATE OF GEORGIA
WITHHOLDING CERTIFICATE FOR PENSION OR ANNUITY PAYMENTS

What is Form G-4P? Recipients of income from annuity, pension, and certain other deferred compensation plans use this form to tell payors whether to withhold income tax and on what basis. Recipients with a large amount of income not subject to withholding (such as interest or dividends), should consider making estimated tax payments using Form 500ES. To obtain Form 500ES, call 1-877-423-6711 or download it from our website at dor.georgia.gov.

If you itemize or claim other deductions or you and/or your spouse have more than one source of income subject to withholding or you (and your spouse if filing jointly) qualify to claim the retirement income exclusion, complete Schedule A on page 2 of this form to calculate the number of additional allowances to which you are entitled.

O.C.G.A. § 48-7-101(j) provides that recipients of non-periodic payments made on distributions from pension, annuity, or similar funds, may elect to have tax withheld on such distributions similar to recipients of periodic payments. (Refer to O.C.G.A. § 48-7-100 (8.1) for the definition of "periodic payment.") Payors of such distributions must withhold based upon such elections.

Personal Allowances Worksheet

- A Enter "1" for yourself if you are single and have only one pension or if you are married and have only one pension A _____
- B Enter "1" if your spouse has no income subject to withholding or your spouse's other income is \$1,000 or less B _____
- OR
- C Enter "1" if you will file as head of household on your tax return C _____
- D Enter number of dependents (other than yourself and your spouse) D _____
- E Total allowances (Total of Lines A, B and D or Line C plus Line D) E _____
- Enter here and on Line 2 below. If using Schedule A, enter this number on Line (I) on the reverse side and enter the total from Line (J) on Line 2 below.

Give this entire form (including page 2 "Schedule A") to the payor and keep a copy for your records.

TYPE OR PRINT YOUR FULL NAME	SOCIAL SECURITY NUMBER
HOME ADDRESS (Number and Street or Rural Route)	MARITAL STATUS (check one only)
CITY OR TOWN, STATE, AND ZIP CODE	<input type="checkbox"/> Single <input type="checkbox"/> Head of Household
	<input type="checkbox"/> Married Filing Separate
	Married Filing Joint:
	<input type="checkbox"/> one spouse working <input type="checkbox"/> both spouses working

Check all that apply (see note after Line 1):

- ☐ I elect not to have Georgia income tax withheld from my pension or annuity.
 (NOTE: If you check this box, do not complete Line 2 or Line 3.)
- ☐ I want tax withheld from each pension or annuity payment based on the number of allowances listed here and marital status indicated above.
 Payors should use the same withholding tables that are used for wages. Please see the Employer's Tax Guide on our website at dor.georgia.gov.
- ☐ I want the following additional amount withheld from each pension or annuity payment. \$ _____
 (Enter an amount here only if you completed Line 2.)

 Your Signature

 Date



Dear Retiree:

Fulton County Government is required to comply with the enacted State Law that requires the County's participation in Systematic Alien Verification for Entitlements ("SAVE") Program. The SAVE Program is a federal Initiative designed to aid benefit-granting agencies in determining an applicant's Immigration status, and thereby ensure that only entitled applicants receive federal, state or local benefits and licenses. As required by Georgia Security and Immigration Compliance Act of 2006, as amended, every agency administering or providing Public Benefits is responsible for requiring that applicants for public benefits execute a sworn affidavit to verify lawful presence in the United States.

All retirees receiving retirement, disability, and/or health Insurance benefits are required to complete the "Affidavit Verifying Eligibility Status for Public Benefits Form" enclosed in this letter. This affidavit must be executed in front of a notary and must be returned with a copy of one (1) secure and verifiable document from the list below to the attention of:

Fulton County Department of Finance
Attn: Pension Unit
Employee Benefits Division – Retirees
141 Pryor Street S.W., Suite 7001
Atlanta, GA 30303

Failure to comply could result in delay or suspension of your benefits. If you have questions, please contact Retiree Benefits at 404-612-7606 or via email at Pensionunit@fultoncountygov.gov.

SECURE AND VERIFIABLE DOCUMENTS

- *An Unexpired United States Passport or Passport Card*
- *An Unexpired United States Military Identification Card*
- *An Unexpired Driver's License Issued by one of the United States*
- *An Unexpired Identification card Issued by the United States*
- *An Unexpired Tribal Identification Card of a federally recognized Native American Tribe*
- *An Unexpired US Permanent Resident Card or Alien Registration Receipt Card*
- *An Unexpired Employment Authorization Document that contains a photograph of the bearer*
- *An Unexpired Merchant mariner Document or Credential Issued by U.S. Coast Guard*
- *An Unexpired Free and Secure Trade (FAST) card*
- *An Unexpired Certificate of Citizenship Issued by the United States Department of Citizenship*
- *An Unexpired Certificate of naturalization issued by the United States Department of Citizenship*
- *An Unexpired Passport Issued by a Foreign Government provided that such passport is accompanied by a United States Department of Homeland Security ("DHA") Form I-94A, DHS Form I-94W, or other federal form specifying on individual's lawful presence Under Federal Immigration law.*

Sincerely,

Melissa Barnett
Interim Employee Benefits Manager

Fulton County Government
Affidavit Verifying Eligibility Status for Public Benefit(s)



Pursuant to the *Georgia Security and Immigration Compliance Act* of 2006 (Senate Bill 529.GSICA), every agency administering or providing public benefits is responsible for determining U.S. citizenship or lawful alien status of applicants for said benefits. (O.C.G.A. § 50-36-1)

By executing this affidavit under oath, as an applicant for a retirement, disability, and/or health insurance benefits, the undersigned applicant verifies one of the following with respect to his/her application for a public benefit from Fulton County Government.

1. _____ I am a United States citizen.
2. _____ I am a legal permanent resident of the United States.
3. _____ I am a qualified alien or non-immigrant under the *Federal Immigration and Nationality Act* with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure verifiable document listed below, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- An Unexpired **United States Passport or Passport Card**
- An Unexpired **United States Military Identification Card**
- An Unexpired **Driver's License** issued within the United States
- An Unexpired **identification card** issued within the United States
- An Unexpired **Tribal Identification Card** of a federally recognized Native American Tribe
- An Unexpired **US Permanent Resident Card or Alien Registration Receipt Card**
- An Unexpired **Employment Authorization Document** that contains a photograph of the bearer
- An Unexpired **Merchant Mariner Document or Credential** issued by U.S. Coast Guard
- An Unexpired **Free and Secure Trade (FAST) Card**
- An Unexpired **Certificate of Citizenship** issued by the United States Department of Citizenship
- An Unexpired **Certificate of Naturalization** issued by the United States Department of Citizenship
- An Unexpired **Passport issued by a Foreign Government** provided that such passport is accompanied by a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law.

The secure and verifiable document provided with this affidavit can best be classified as:

(list document and provide a copy) _____

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20 and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state)

—

Signature of Applicant

—

Printed Name of Applicant

Subscribed and sworn before me on this the

_____ day of _____, 20_____

Notary public: _____

My commission expires: _____



CHECK YOUR RETIREMENT PLAN

401A (New Plan) (DB) Defined Benefit (Old Plan)

2020 Retiree/Beneficiary Annual Enrollment Form

INFORMATION ABOUT YOU

Retiree Name (First Name, Last Name):

Social Security #:

Are you age 65 or older / Medicare Eligible: ☐ Yes ☐ No

Retiree Home Address:

Street:

City:

State:

Zip:

Home Phone:

Cell Phone:

Email:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Date of Hire: / /

Date Retired: / /

Are you eligible for Medicare?

☐ Part A / Effective date: / /

☐ Part B / Effective date: / /

Is your spouse eligible for Medicare?

☐ Part A / Effective date: / /

☐ Part B / Effective date: / /

Is your or your spouse's Medicare coverage related to end-stage renal disease? ☐ Yes ☐ No

YOUR HEALTH PLAN OPTIONS

Medical Plan Coverage Tier (Select One):

☐ Retiree Only

☐ Retiree + Spouse

☐ Retiree + Child(ren)

☐ Family

☐ Waive Coverage

Medical Plan Options—Retirees Under Age 65:
(Non-Medicare)SELECT ONE MEDICAL PLAN

☐ HSA Plan (Anthem BlueCross BlueShield)
☐ HMO Plan ((Anthem BlueCross BlueShield) - NEW
☐ POS Plan (BlueCross BlueShield of Georgia)
☐ HMO Plan (Kaiser Permanente)

Medical Plan Options—Retirees Age 65 or Older:
(Medicare) SELECT ONE MEDICAL PLAN

☐ Basic Medicare Advantage Plan (Aetna) *
☐ Enhanced Aetna Medicare Advantage Plan (Aetna)*
☐ Medicare Indemnity Plan (Anthem BlueCross BlueShield)
☐ Medicare HMO Plan (Anthem BlueCross BlueShield)
☐ PPO Plus Plan (Anthem BCBS —current participants only) Closed

* To enroll in the Basic Aetna Medicare Advantage Plan or the Enhanced Aetna Medicare Advantage Plan for the first time, please contact Aetna directly: (800) 307-4830.

Dental Plan (SELECT ONE DENTAL PLAN)

☐ Comprehensive Dental PPO Plan

☐ Dental HMO Plan - Primary Dentist Office ID (Required)

Dental Plan Coverage Tier (Select One):

☐ Retiree Only

☐ Retiree + Spouse

☐ Retiree + Child(ren)

☐ Family

☐ Waive Coverage

Vision Plan Coverage Tier (Select One):

☐ Retiree Only

☐ Retiree + Spouse

☐ Retiree + Child(ren)

☐ Family

☐ Waive Coverage

INDIVIDUALS TO BE COVERED*

If any of your dependents listed above live at an address that is different than yours, please complete the following:

Name(s)

Address(es)

When enrolling dependents for the first time, you must submit with this enrollment form supporting documentation appropriate for the relationship of the dependent to you (e.g., marriage certificate, birth certificate, adoption placement papers, court-ordered child health coverage support affidavit, physician verification of permanent disability).

IF YOU ARE DECLINING COVERAGE

By completing this section, I acknowledge that I was given the opportunity to enroll for 2020 Fulton County health care coverage and am choosing not to enroll in one or more of the above benefit plans. I understand that if my dependents or I wish to enroll at a later date for any of the coverage(s) I have declined, I / they will be required to submit a new Enrollment Form and coverage may be subject to late enrollee provisions, as allowed by law and as directed by my employer.

Reason for refusal: (Please check all that apply)

☐ Other group coverage sponsored by my employer

☐ Other group coverage sponsored by my spouse's employer

☐ Other group coverage sponsored by another organization

☐ Other reasons (Please explain below)

FOR OTHER COVERAGE

Carrier:

Plan Number:

Telephone Number:

Retiree Signature

Date

I hereby authorize a deduction to be made from my pay or drafted from my bank account on file (if applicable) as my share of the premium cost, as authorized by the Fulton County Board of Commissions. I certify the above information is true and correct and I am entitled to the coverage requested. I declare that all statements and information made hereon are complete and true to the best of my knowledge, I understand that any misstatements or omissions may void all coverage applied for any member on this application on a retroactive basis for up to two (2) years from the contract effective date.

Return completed form with any required supporting documentation postmarked by **October 18, 2019** to
Fulton County Pension Office
141 Pryor Street S.W. Suite 7001
Atlanta, GA 30303